Disability Questionnaire & Activities of Daily Living

CIGNA Group Insurance
Life • Accident • Disability
Connecticut General Life Insurance Company
Insurance Company of North America
CIGNA Life Insurance Company of New York

GB-609428 (04/2004)

FRAUD WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the reverse side of this form: ***California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.***

Name:	**Social Security No.:**
Address:	**Telephone No.:**

1. In your own words, tell us why you cannot work in your own or in any occupation.

_____

_____

_____

2. What is primary physical and/or mental condition preventing you from working now?

_____

_____

_____

3. Can you drive? ☐ Yes ☐ No How far? _____

4. What time do you get up in the morning? _____ What time do you go to bed? _____

5. Where do you live? ☐ Apartment ☐ House

   How many floors in the apartment/house? _____ Does it have an elevator? ☐ Yes ☐ No

   Do you use any special equipment - ramps, handrails, wheelchair? ☐ Yes ☐ No
   If yes, describe _____

6. How often do you use the computer? _____

   What computer programs or software can you use? _____

   _____

7. Check the things you do regularly:

	Activity	**Hours per day?**	**Days per week?**
☐	Cook		
☐	Clean		
☐	Shop		
☐	Laundry		
☐	Yardwork		
☐	Gardening		
☐	Read		
☐	Watch TV		
☐	Other (school, attend religious services, volunteer work, etc.)		

   What do you do for recreation? _____

   _____

8. Are there things you attend to with regard to your personal needs (grooming, dressing, etc.)?

   _____

   _____

9. Do you go for walks? ☐ Yes ☐ No How often? _____
   How far do you walk? _____ For how long? _____

10. Do you engage in a regular exercise program? ☐ Yes ☐ No
Where (home, gym, etc.) _____
How often? _____
Describe your exercise program _____

11. Please circle the highest grade you completed in school:

1 2 3 4 5 6 7 8 9 10 11 12 GED High School Diploma

College? 1 yr. 2 yrs. 3 yrs. 4 yrs. BA/BS Degree Masters DegreeOther

Type of degree? (Business, History, Social Sciences, etc.) _____
Date Received _____

List any professional/educational certificates, licenses, etc. awarded _____

_____

List any vocational programs you have attended/completed _____

In the last 3 years, what type of certificates or licenses have you received? _____

_____

12. Are you taking any professional/educational/vocational classes now? ☐ Yes ☐ No
Please list them _____

13. Are you working? ☐ Yes ☐ No
If so, please list how many hours per day you work, and the name of your employer. _____

_____

14. Have you discussed return to work with your physician? ☐ Yes ☐ No
What does your physician say about returning to work? _____

15. When do you expect to return to work? _____
Will you return to your regular occupation? ☐ Yes ☐ No If no, why not? _____
Will you return to Modified job? ☐ Yes ☐ No If no, why not? _____

16. Do you know of any positions within your company that you would be interested in? ☐ Yes ☐ No
If yes, what position? _____

17. If unable to return to regular position, would you be interested in exploring your career options? ☐ Yes ☐ No

Employment History

1. Job Title:	Employed date: From: Through:
Major Duties:	Minor Duties:
Tools/Equipment used:	Machinery/Computers used:
2. Job Title:	**Employed date: From: Through:**
Major Duties:	Minor Duties:
Tools/Equipment used:	Machinery/Computers used:
3. Job Title:	**Employed date: From: Through:**
Major Duties:	Minor Duties:
Tools/Equipment used:	Machinery/Computers used:

18. Have you ever owned or operated your own business? ☐ Yes ☐ No
Do you own, operate or have ownership interest in a business now? ☐ Yes ☐ No
Business Name _____

19. Are you married? ☐ Yes ☐ No
If yes, please provide: Spouse's Name: _____ DOB: ____/____/____
Spouse's SSN: _____

Do you have any children under age 18? ☐ Yes ☐ No
Please list their names and dates of birth in order:

_____
_____
_____

Do you have any handicapped children over 18? ☐ Yes ☐ No

20. List any prescription medications you take: Use other side if you need more space.

Medication	Dose	Frequency	Medication	Dose	Frequency

21. List any doctor(s) you see regularly. Use the other side if you need more room.

Doctor's Name/Speciality:		Doctor's Name/Speciality:	
Address:		Address:	
Telephone #:	Fax #:	Telephone #:	Fax #:
Frequency of visits:	Date of last visit:	Frequency of visits:	Date of last visit:
Doctor's Name/Speciality:		Doctor's Name/Speciality:	
Address:		Address:	
Telephone #:	Fax #:	Telephone #:	Fax #:
Frequency of visits:	Date of last visit:	Frequency of visits:	Date of last visit:

22. Are you right handed or left handed? ☐ Right ☐ Left
What is your height? _____ What is your date of birth? _____
What is your weight? _____

23. Are you a veteran? ☐ Yes ☐ No
If yes, have you applied for VA benefits for <u>this</u> disability? ☐ Yes ☐ No
Please attach a copy of your VA disability award.

24. What other types of income/money/compensation/benefits are you receiving or eligible to receive?

			$ Amount/Frequency	Date Began	Date Paid Through
☐ Yes	☐ No	Salary Continuance			
☐ Yes	☐ No	State Disability Benefits			
☐ Yes	☐ No	Group Disability Benefits			
☐ Yes	☐ No	Workers' Compensation			
☐ Yes	☐ No	Pension Benefits			
☐ Yes	☐ No	Social Security Disability Benefits			
☐ Yes	☐ No	No-Fault Auto Disability Insurance			
☐ Yes	☐ No	Any Other Disability Income			

I certify that the information in this document is true and correct.

Signature _____ **Date** _____

DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print): _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be disclosed to anyone EXCEPT: a) reinsuring companies; b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c) fraud or overinsurance detection bureaus; d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; e) for audit or statistical purposes; f) as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative: _____ Date: _____

Relationship,
if other than Claimant: _____ Claimant's Social Security Number: _____

Company Name: _____

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federal regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient.

IMPORTANT CLAIM NOTICE

California Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.